Individualism or activism for health in hard times?

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Received: 13 August 2012 / Accepted: 21 January 2013 / Published online: 2 February 2013
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Introduction

Global economic conditions are forcing many governments to pursue tighter public policies at the same time as politics in westernised countries are shifting towards conservatism. Conservative governments are sensitive to not upsetting commercial vested interests but also to be seen to be upholding of individual rights. In hard times, economic conservatism and personal responsibility are an attractive political option because they (falsely) promise results within a short time frame. They are also relatively simple (Gangolli et al. 2005) and offer financial incentives for savings in health-care services, especially for chronic diseases (Bernier 2007). Individualism is an appealing ideology because it holds people responsible for their own actions, not government, and the consequences that these may have. In hard times this can mean an extra burden for many people that face the prospect of unemployment, lower pay, less benefits, homelessness and poorer health. Whilst people are made to feel more responsible for their own health it can also mean a greater loss of individual control in their lives.

Discussion

Public health programmes that target individuals to change their ‘unhealthy’ behaviours, for example, by encouraging exercise and eating a balanced diet, are generally, but not exclusively, top-down. Top-down programmes, by design,

address government health agendas that are not expressed as community needs, by design, bottom-up. Australia’s ‘Swap it, don’t swap’ campaign uses a character called ‘Eric’, a blue balloon type figure, who urges others to swap unhealthy aspects of their lifestyle such as physical inactivity, for healthier lifestyle habits. However, the changes necessary for ‘Eric’ to lead a healthier life actually requires a change in the structures in which he lives such as a safe neighbourhood (Baum 2011). A political commitment to address the broader determinants of health only to shift to a much narrower lifestyle intervention is a political trend that has been termed the ‘lifestyle drift’. There are other examples of programmes that inevitably lead to the ‘victim blaming’ of individuals who are unwilling to embrace the advice given to them or to change their unhealthy lifestyles. Nicholas Freudenberg (2000) reviewed 135 top-down health intervention studies in the USA designed to prevent heart disease, substance abuse, HIV and violence. The review found that many of the interventions were unsuccessful in meeting their objectives because they addressed a specific problem and targeted the individual rather than the social and economic factors which were clearly influencing both the existence of the problem as well as the overall health of the community. The interventions reviewed were of a limited duration and specifically designed for an urban context although most did not fully take into account the unique nature of the population group. To be successful, public health programmes often require policy and structural change such as a review of the food chain in Finland by the North Karelia experiment (Puska 2002), as well as accompanying, tailored community-based actions.

The framing of health as individualized creates another obstacle for public health. The personalization of health provides a focus on the ‘struggle’ against a disease or illness. Health is individualized by people who regard it as

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personal in nature and responsible for the things, both good and bad, that happen to them. Although individuals may be committed to change, this is only at the personal level and does not address the broader structural level. People who are passionate about, for example, climate change, are able to collectively mobilize themselves to publically protest because it is an issue that affects us all. But obesity and heart disease affect us individually, and the response of people is to deal with these issues themselves, usually at a personal level.

Top-down campaigns have had some success with the educated and economically advantaged in society, for example, between 1998 and 2004, there was a 9% decrease in smoking in the lowest quintile in Australia compared to a 35% decrease in the highest quintile (Baum 2007). Likewise, between 2000 and 2005, top-down efforts in Saskatchewan, Canada, to increase physical activity resulted in 30% people becoming more active. The change in physical activity had occurred in the higher socio-economic groups with little measurable impact on the health of the low socio-economic, ethnic minorities or indigenous people (Saskatoon Regional Health Authority 2005). As a consequence, top-down public health may have had little effect in closing the gap between the ‘healthy wealthy’ at the top of the social gradient and low socio-economic groups further down the gradient. It may even, at least temporarily, have led to an increase in health inequalities (Baum 2007). As Freudenberg (2000) suggests this type of success could be used to tailor future efforts to meet the needs of the socially disadvantaged. To be successful, public health programmes must actively include community needs, experiences and expertise in their design. Motivation to change behaviour must come from within the community as well as from the expert application of tailored interventions. This requires an acceptance of ‘lay knowledge’ as being valid, a concept that can be alien to some professionals (Syme 2004), and the strong cooperation from all actors involved in public health programmes in order to begin to address health inequalities.

Conclusion

There is not a simple solution, especially in the current fiscal climate that encourages individualism over a broader structural and community approach to public health. However, neither is it an either/or situation. There are ways to use both top-down and bottom-up approaches within the same programme (Laverack and Labonte 2000) as an effective strategy for

promoting health. Leonard Syme (2004), an influential American epidemiologist, suggests that this means changing the way we plan, deliver and evaluate public health. It is how we train the next generation of practitioners, organise and finance programmes, conduct research and view our role as ‘public health professionals’. I agree and go further to suggest that public health can play an even stronger role by encouraging people to engage in health activism as a way forward when innovative ideas in professional practice are lacking. The use of unconventional tactics has been a successful strategy, for example, by giving women more choice for birth control and for surgical treatment of breast cancer in the twentieth century (Laverack 2013). Historically, what has defined a contemporary public health practice has been its willingness to work with others to address the causes of social injustice and health inequities in society. We can choose to do this or we can continue to conveniently shift responsibility for health onto the individual.

Conflict of interest The authors declare that they have no conflict of interest.

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